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Site of Culprit lesion	LAD		RCA		LCx	
	CGM	ECG	CGM	ECG	CGM	ECG
Sensitivity	63.6%	36.4%	42.9%	57.1%	42.9%	33.3%
Specificity	93.3%	93.3%	100.0%	100.0%	94.7%	80.0%
Positive predictive value	87.5%	80.0%	100.0%	100.0%	75.0%	33.3%
Negative predictive value	77.8%	66.7%	82.6%	86.4%	81.8%	80.0%
Kappa statistic for agreement	0.59 p=0.002	0.32, p=0.06	0.52, p=0.002	0.66, p<0.001	0.44, p=0.02	0.08, p=0.69

angiography and were interpreted by independent investigators, with the location of the culprit lesion indicated by each recording recorded. Based on coronary angiography, the site of the culprit lesion was then determined by the operating interventionist. Measures of diagnostic performance were than calculated for CGM and the 12-lead ECG for each lesion site: left anterior descending (LAD), left circumflex (LCx) and right coronary (RCA). Kappa statistic for agreement was calculated between CGM, 12-lead ECG and coronary angiography.

Results Thirty patients (aged 67.5±10.8; 76.9% male) were recruited. Markers of diagnostic performance are shown in the table. Both CGM and the 12-lead ECG were able to provide ischaemia localising information in 57.7% of participants.

Conclusion Although CGM is superior to the 12-lead ECG at accurately locating the culprit lesion site in patients with NSTEMI, it is only able to provide ischaemia localising information in a similar number of patients as the 12-lead ECG.

61 INVESTIGATING THE SMOKERS PARADOX BY GENDER: DIFFERENCES IN SURVIVAL FOLLOWING ACUTE ST-SEGMENT ELEVATION MYOCARDIAL INFARCTION

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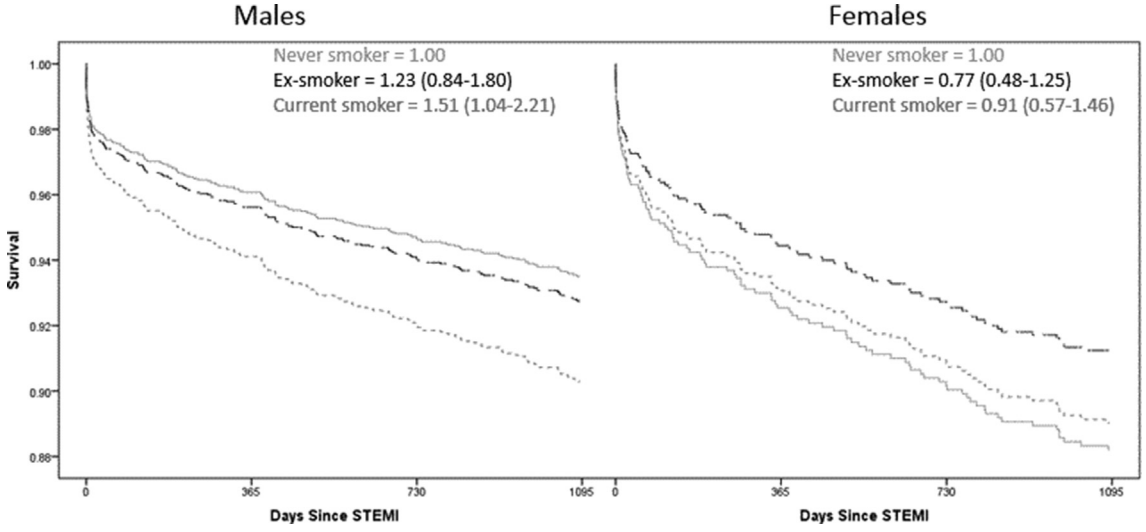
Background The smoker's paradox, where smokers have better survival after acute myocardial infarction, was predominantly observed in the thrombolytic era. Evidence for the smoker's paradox in the current era of primary percutaneous coronary intervention (PCI) therapy is limited and inconsistent. Furthermore, there is no data regarding gender differences relating to this phenomenon.

Methods Data were collected for all patients with acute STEMI undergoing primary PCI at South Yorkshire Cardiothoracic Centre, UK between 2009 and 2014. Cox regression



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analysis was used to assess differences in survival (at 30 days, 1 year, and 3 years) by smoking status and gender after adjustment for confounding factors.

Results There were 2726 STEMI patients (26.4% female) during the study period. Male patients were younger than females (61.0±12.1 vs 65.5±13.1 years, p=0.02). Smoking prevalence was similar in both genders (males 48.3%, females 48.0%), but a greater proportion of females had never smoked (27.8% vs 21.0%, p=0.01). Male current smokers had a significantly worse 3 year mortality than never smokers (HR 1.51, 95% CI 1.04–2.21, p=0.03). In female patients smoking status had no significant effect on survival (p=0.58), which could potentially be due to the modest number (n=723) of female patients in this study. Overall survival was similar in both males and females (p=0.72).

Conclusions There was no evidence of a smoker's paradox in STEMI patients followed up to 3 years in either males or females.

62 ANGIOGRAPHY AFTER CABG SURGERY; SOLVING THE PROBLEM OF MISSING SURGICAL RECORDS WITH A STERNAL WIRE CODE

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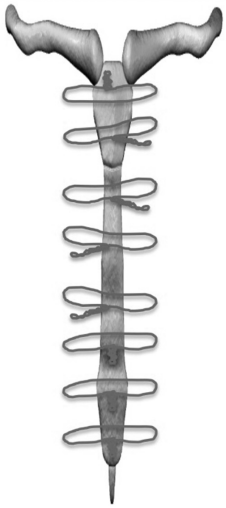
Background The recommendation that surgical records (graft notes) are obtained before coronary angiography in patients with previous coronary artery bypass graft (CABG) surgery is not always followed. Lack of prior information on the number and origin of grafts increases procedure time, complexity and risk to patients. Here, we determine the proportion of angiograms undertaken without graft notes, and propose a code to permanently provide this information.

Methods For patients undergoing angiography at the Barts Heart Centre, London (September 2015-September 2016), records of patients with previous CABG were retrieved. From the procedure reports, we identified patients without graft notes and the indication for the angiogram.

Results Of 6483 patients undergoing angiography, 559 had undergone previous CABG surgery; graft notes were unavailable in 91/559 patients (16%). In 88/91 patients (97%), angiography was an unplanned emergency procedure; 84 acute coronary syndromes and 4 out-of-hospital arrests. Three patients had planned angiograms for stable angina. In 20/91 patients additional imaging investigations were required because of uncertainty over whether all grafts had been identified and one patient consequently developed pulmonary oedema due to a large contrast load.

Conclusion About 1 in 6 patients with previous CABG surgery, who require coronary angiography, undergo this procedure without graft notes, almost all in the emergency setting. A clinical code, based on the orientation of the wires used to close the sternum after CABG, could provide a permanent

Sternal wire code for recording number and origin of coronary artery bypass grafts

Sternal wire code	Interpretation	Example of code for CABG with two grafts with subclavian origin (internal mammaries) and two grafts with aortic origin (saphenous veins)
If wire nearest clavicle points up and all other wires point down 	Code is in use	
If wire points down and left*  (use one wire per graft)	Graft has subclavian artery origin	
If wire points down and right*  (use one wire per graft)	Graft has aortic origin	
If wire points straight down  (use for all remaining wires)	End of code (wires provide no graft information)	

Sternal wire code is visible on x-ray or fluoroscopy during the angiogram

* anatomical left and right

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